Glossary

Actively at Work

An employee is considered actively at work on an employer's scheduled workday if he is performing in the usual manner all of the regular duties of his work on a full-time basis on that day. He may be doing so at his usual work place or at another place if required to travel. An employee is considered actively at work on a paid vacation day or on a day that is not one of the employer's scheduled workdays, only if he was actively at work on the preceding scheduled workday.

Allowable Charge

The maximum amount a health plan (such as the State Health Plan, an HMO or Medicare) will pay for a covered service or for a product, such as a drug. Network providers have agreed to accept the allowable charge. An "actual charge" is the provider's full price for a covered service or a product before any negotiated discounts are applied.

Annual Enrollment

A period during which eligible subscribers may change health plans only (SHP Savings to Standard, Standard to Savings, SHP to an HMO, HMO to SHP or HMO to another HMO). The only other health plan changes allowed are changing to or from the TRICARE Supplement. Eligible subscribers may only change to or from the Medicare Supplemental Plan within 31 days of eligibility or during open enrollment, which occurs in October of odd-numbered years. The Medicare Supplemental Plan is not offered to active subscribers. See also *Open Enrollment*.

Basic Salary

The actual amount an employee is paid by the employer each year, including merit and longevity increases. Basic salary does not include commissions, annuities, bonuses, overtime or incentive pay. For a teacher, basic salary does not include compensation for summer school.

Child

See *Dependent Child*.

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985. This act requires that continuation of group insurance coverage be offered to covered persons who lose health or dental coverage due to a qualifying event as defined in the act. See also *Qualifying Event*.

Coinsurance

Coinsurance is the percentage of covered medical expenses a subscriber must pay in conjunction with the percentage paid by an insurance plan. These amounts are called coinsurance because the subscriber and the insurance plan share the cost of healthcare.

Coinsurance Maximum

The coinsurance maximum is the most money a subscriber would pay in coinsurance each year, not including copayments and deductibles, before an insurance plan begins to pay 100 percent of the allowable charge for covered expenses. This does not apply to the Medicare Supplemental Plan.

Coordination of Benefits

A system to eliminate duplication of benefits when a person is covered under more than one group plan. Benefits paid under the two plans may not exceed 100 percent of the claim.

Copayment

A copayment is a fixed dollar amount a subscriber must pay for covered expenses in addition to what is paid by an insurance plan. These amounts are called copayments because the subscriber and the insurance plan share the cost of healthcare.

Copayment Maximum

The most money in copayments a subscriber would pay each year before an insurance plan begins to pay the entire allowable charge for covered expenses.

Covered Dental Expense

An expense that is provided for, and deemed medically necessary by, the plan, up to the maximum amount listed in the Schedule of Dental Procedures and Allowable Charges (fee schedule), and is not excluded by any term, condition, limitation or exclusion of the plan. See also *Dental Schedule of Procedures and Allowable Charges*.

Covered Medical Expense

A medical expense that is considered medically necessary and is not excluded by any term, condition, limitation or exclusion of the plan. See also *Medically Necessary.*

Covered Person

A person (employee, retiree, survivor, COBRA participant or dependent), who has met the eligibility requirements, and is enrolled in an insurance plan. See also *Subscriber*.

Creditable Coverage

Prior coverage under a group health plan or insurance coverage or health benefits described or defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Proof of creditable coverage (a form from your previous insurance company, listing your dates of coverage) may be used to reduce a pre-existing condition limitation period, provided the coverage was continuous (any break in coverage did not exceed 62 days). See also *Pre-existing Condition.*

Deductible

The amount a subscriber must pay each year, if it is an annual deductible, or each time a service is received, if it is a per-occurrence deductible, toward covered expenses before the insurance plan begins to pay benefits.

Deferred Effective Date

A delay in the date insurance coverage starts. It may apply to an employee who is absent from work due to an injury or sickness on the date coverage would have begun. The date coverage starts is then postponed until the individual returns to work as an active, permanent, full-time employee for one full day. See also *Actively at Work*.

Dental Course of Treatment

All treatment performed in the mouth during one or more sessions as the result of the same diagnosis. Treatment includes examination, X-rays, prophylaxis and any complications arising from such treatment. Note: Some surgical procedures may be covered by a subscriber's health plan.

Dental Schedule of Procedures and Allowable Charges

The list of dental procedures covered by the State Dental Plan and the amount the plan will pay for each procedure.

Dependent Child

An unmarried child, under 19 years of age (or under age 25 if a full-time student), and who is principally dependent (more than 50 percent) upon the subscriber for maintenance and support. The child must be: (1) the natural or adopted child, stepchild, foster child or child for whom the subscriber has legal custody and who resides in the subscriber's home in a parent-child relationship; or (2) for whom the subscriber provides support and maintenance due to a court order. See also *Foster Child, Full-time Student* and *Incapacitated Child*.

Dependent Spouse

A lawful spouse of a subscriber, or a former spouse who is required to be covered by a divorce decree or court order, but not both spouses. If a spouse is also eligible for coverage or benefits as an employee of a participating employer, the spouse may not be covered as a dependent. However, a part-time teacher, who is the spouse of a covered employee, may be covered as an employee or as a dependent, but not as both.

Eligible Employee

- Is employed by the state, a school district or a participating local subdivision
- Is in a permanent full-time position as defined by the plan
- Receives compensation from a department, agency, board, commission or institution of the state, a school district or a participating local subdivision.

Eligible employees also include clerical and administrative employees of the S.C. General Assembly and judges in the state courts. S.C. General Assembly members and elected members of participating county or municipal councils who also participate in the S.C. Retirement Systems (SCRS) are considered employees for insurance purposes. If you work for more than one participating employer, please contact your benefits administrator for further information. Permanent, part-time teachers are eligible for state health, dental, Dental Plus, MoneyPlu$ and vision care benefits.

Enrollment Date

(1) The hire date for an employee; (2) the effective date of coverage for an individual who enrolls under a special eligibility situation and for a late entrant; and (3) the retirement date for a retiree.

Exclusion

A specific condition or circumstance for which an insurance plan or policy will not provide benefits.

Extended Care Benefits

Benefits that provide for medical care in a more cost-effective setting when hospitalization is not required or necessary. Extended care benefits include home healthcare, skilled nursing facility care, hospice care and alternative treatment plans.

Foster Child

A child who is placed with the employee by an authorized placement agency and who is cared for by the employee as if the child were his own child.

Funded Retiree

A funded retiree is one who is eligible for an employer contribution to his or her retiree insurance premiums.

Full-time Student

An unmarried person, who is over 19 years of age but less than 25 years old, who is enrolled in and attending a high school; a trade, vocational or technical school; or a college or university on a full-time basis, as defined by the institution. Correspondence courses do not count toward eligibility as a full-time student.

Under the TRICARE Supplement, eligibility for coverage as a full-time student ends at age 23.

Health Maintenance Organization (HMO)

A managed care plan that has contracts with healthcare providers (doctors, hospitals, etc.) that form a provider network. HMO subscribers are required to see only providers within this network. If a subscriber receives care outside of the network, the HMO will not pay benefits for these services unless the care was pre-authorized or deemed an emergency. A subscriber chooses a primary care physician (PCP) who coordinates all aspects of his healthcare. To receive benefits, a subscriber must receive a referral from his PCP before he can see a specialist.

Home Healthcare

Part-time nursing care; health aide service; or physical, occupational or speech therapy provided by an approved home healthcare agency and given in the subscriber's home. These services do not include custodial care or care given by a person who ordinarily lives in the home or a member of the subscriber's family or of the spouse's family.

Hospital

A legally designated and operated institution caring for the sick, such as a general hospital; children's hospital; eye, ear, nose and throat hospital; maternity hospital or an ambulatory surgical center. "Hospital" also includes a legally constituted and operational psychiatric facility for the treatment of mental or nervous conditions or substance abuse. Hospitals must provide inpatient care given by, or supervised by, a staff of licensed physicians and must provide continuous, 24-hour services by licensed registered nurses who are physically present and on duty. Nursing homes, rest homes, homes for the aged and convalescent homes are typically not considered hospitals under insurance plans, whether or not they are affiliated with a hospital.

Identification Number

Under most plans, the covered person's Social Security Number is his identification number. Identification cards are issued by the insurance plan. Note for retirees: Under the State Health Plan Savings, Standard or Medicare Supplemental plan, the retiree's Social Security Number is used by all covered family members. Use the number listed on the Medicare card for Medicare claims and information. Note for survivors: For surviving spouses and surviving spouses with covered children, the surviving spouse's Social Security Number is used for all covered family members. For surviving children only, the youngest child's Social Security Number is used.

Incapacitated Child

An unmarried child who is incapable of self-sustaining employment because of mental illness or physical disability, and who is principally dependent (more than 50 percent) on the subscriber for maintenance and support. Incapacitation must have begun before age 19 or while an eligible, covered dependent was a full-time student. If eligible but not previously covered, the child may not be added until the next open enrollment period (or within 31 days of a special eligibility situation), and coverage is subject to pre-existing condition limitations.

Incurred Expense

An expense is considered incurred on the date services were provided or supplies were received.

Injury

Accidental damage to the body that requires treatment by a physician. Any loss that results from the injury must be independent of sickness or other causes.

Late Entrant

A full-time employee or eligible retiree, and any eligible dependent of that employee or retiree, who is not enrolled within 31 days of that person's first date of eligibility and who later enrolls during an open enrollment period. A late entrant is subject to the pre-existing condition exclusion for 18 months after coverage begins.

Local Subdivision

Any participating employer covered by local jurisdiction rather than state. Examples of local subdivisions include: counties, councils on aging, commissions on alcohol and other drug abuse, special purpose districts, community action agencies, disabilities and special needs boards, municipalities, recreation districts, hospital districts and councils of government. Since 1985, the General Assembly has passed legislation extending voluntary participation in the state insurance benefits program to certain local subdivisions. To be eligible to participate in the state insurance benefits program, a public employer in South Carolina must fall within one of the categories established by statute (Section 1-11-720 of the 1976 S.C. Code of Laws, as amended).

Medi-Call

Medi-Call reviews subscribers' use of the State Health Plan and must pre-authorize some benefits provided by the plan. Medi-Call helps subscribers receive appropriate medical care in the most beneficial, cost-effective manner. Note: Retirees and dependents entitled to Medicare must call Medi-Call for home healthcare, hospice, durable medical equipment, Veterans Administration hospital services and when a hospital stay exceeds the number of days allowed by Medicare. For details, see pages 30-31.

Medically Necessary

Services or supplies ordered by a physician or behavioral healthcare provider to identify or treat an illness or injury. Services and supplies must be given in accordance with proper medical practice in the medical specialty or field when the patient receives the service and must be in the least costly setting required for the patient's condition. The service must be consistent with the patient's illness, injury or condition and must be required for reasons other than the patient's convenience. The fact that a physician prescribes a service or supply does not necessarily mean it is medically necessary.

Mental Health and Substance Abuse Provider

A physician, psychiatrist, health professional or institution that is part of the provider network administered by the APS Healthcare, Inc.

Non-funded Retiree

A non-funded retiree is a retiree who does not qualify for an employer contribution to the cost of his insurance and who must pay the full premium.

Non-preferred Brand Drug

A medication that is not on the preferred brand list and, therefore, carries a higher copayment than a generic or preferred brand drug. There is an effective alternative, either as a generic or as a preferred brand drug, for all medications on the non-preferred brand list.

Notice of Election Form

The Notice of Election (NOE) form is the application form used to enroll in benefits; add or delete dependents; or change a subscriber's coverage level, beneficiary, name or address.

Open Enrollment

A period during which eligible employees, retirees, survivors and COBRA subscribers may enroll in or drop their own coverage and add or drop eligible dependents to/from a health plan without regard to any special eligibility situations. Retirees may also change to and from the Medicare Supplemental Plan. Open enrollment is held in odd-numbered years during October, and changes become effective the following January 1.

Optional Employer

See *Local Subdivision.*

Out-of-Network Differential

If you choose to go to a healthcare provider that does not participate in a State Health Plan network, you will be responsible for a higher coinsurance percentage of your covered medical expenses, and you may be billed the difference between the allowed and actual charge. This out-of-network differential applies to all State Health Plan networks except the Mental Health and Substance Abuse and Pharmacy networks, where no out-of-network benefits are provided.

Out-of-pocket Maximum

The most money a covered person will be required to pay a year in deductibles, copayments and coinsurance. The amounts are set by each insurance plan.

Part-time Teacher

A teacher, who is in a permanent position, and who works at least 15 hours, but no more than 29 hours, a week at a South Carolina public school, the S.C. Department of Juvenile Justice or the S.C. Department of Corrections. He must also be in a contract position and receive an Education Improvement Act (EIA) salary supplement. A part-time teacher is eligible for state health, dental, Dental Plus, MoneyPlu$ and Vision Care benefits. Premiums are determined by the number of hours an eligible part-time teacher works each week.

Participating Employer

A state agency, public school district, county, municipality or other group participating in the plan.

"Pay-the-Difference" Policy

Under the State Health Plan, if a generic drug is available and a subscriber chooses to purchase or his doctor prescribes the brand name medication instead, the benefit will be limited to the amount payable for the generic medication. The subscriber will be responsible for paying the difference in the benefit between the brand name drug and the generic drug, plus the generic copayment. The difference does not apply to the subscriber's annual copayment maximum.

Per-occurrence Deductible

The amount a covered person must pay each time he visits a physician's office or receives an emergency room, inpatient or outpatient hospital service before the health plan begins to pay benefits.

Physician

A licensed medical doctor, dentist, oral surgeon, podiatrist, osteopath, chiropractor, psychiatrist or licensed counseling or clinical psychologist.

Plan Year

January 1 through December 31.

Point of Service (POS)

A managed care plan that allows a subscriber to choose providers or specialists within the plan's network as referred by his primary care physician, or subscribers can self-refer to a provider outside the network. If a subscriber uses out-of-network services, benefits are paid at a reduced level.

Pre-existing Condition

Any medical condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received by a licensed healthcare provider or practitioner in the six months before the covered person's enrollment date. Benefits will not be paid for a pre-existing condition for the first 12 months (18 months for a late entrant) after enrollment. Pregnancy does not constitute a pre-existing condition. See also *Creditable Coverage*.

Preferred Brand Drugs

Medications that have been determined safe, effective and available at a lower cost by Medco's Pharmacy and Therapeutics Committee. A list of preferred brand medications is available at www.medco.com.

Preferred Provider Organization (PPO)

A PPO is a type of health or dental plan that is similar to a fee-for-service plan. A PPO has arrangements with doctors, hospitals and other providers who have agreed to accept the plan's allowable charges for covered medical services as payment in full and will not balance bill you. Participating providers also file claims for you.

Premium

The amount a covered person pays for insurance coverage.

Prescription Drug

Any drug or medicine required to bear the following wording, "Caution: Federal law prohibits dispensing without prescription." Insulin or drugs licensed or accepted for a specific diagnosis as listed in the U.S. Pharmacopoeia Publication, Drug Information for Health Care Professionals, are also considered prescription drugs. Drugs in FDA phase I, II or III testing are not covered.

Primary Care Physician/Doctor

Usually the first contact for healthcare. This is often a family physician, internist, pediatrician, or in some cases, a gynecologist. A primary care physician monitors the patient's health, diagnoses and treats minor health problems and refers the patient to specialists if another level of care is necessary.

Private Duty Nursing Services

Private services of a registered nurse or licensed practical nurse. Services must be certified in writing by a physician as medically necessary.

Provider

Any person (i.e., doctor, nurse, dentist) or facility (i.e., hospital or clinic) that provides healthcare, acting within the scope of his/its license.

Qualifying Event

An event that causes a loss of health and/or dental insurance and allows an extension of coverage for an employee, a spouse or a dependent. Such events include loss of a job, a reduction in hours that makes an employee ineligible for coverage, death, divorce or legal separation, loss of a dependent's eligibility for coverage, eligibility for Medicare by a covered employee or a parent of an eligible dependent child. See also *COBRA*.

Self-insured Plan

A self-insured insurance plan is one in which an employer or group of employers assume direct financial responsibility for the costs of health claims. Employers sponsoring self-insured plans typically contract with an insurance carrier or third party claims processor to provide administrative services for the self-insured plan.

Significant Break in Coverage

Used to apply a pre-existing condition limitation, a period of 63 or more consecutive days during which an individual does not have creditable insurance coverage. Neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. See also *Creditable Coverage*.

Skilled Care

Services provided according to a physician's order, given by or under the direction of a qualified technical or professional healthcare provider. Healthcare providers include registered nurses, licensed practical nurses, physical therapists, speech pathologists and audiologists.

Special Eligibility Situation

A qualifying event that allows eligible employees, retirees, survivors or COBRA subscribers to enroll themselves and/or their eligible dependents in an insurance plan. Examples include: marriage, birth, adoption or placement for adoption. Involuntary loss of other coverage applies only to those who lost coverage. Enrollment changes must be requested within 31 days of the qualifying event. Note: A salary increase does not constitute a special eligibility situation. See also *Qualifying Event*.

Specialty Drugs/Pharmaceuticals

A pharmaceutical product that is generally, but not exclusively, biotechnological in nature. Biotechnological drugs are those manufactured using a live substance rather than a chemical reaction. These high-cost medications are typically used to treat serious conditions.

Spouse

See *Dependent Spouse*.

State Health Plan (SHP)

The term used generally to identify the Savings, Standard, and Medicare Supplemental plans.

Subscriber

An active or retired employee, survivor or COBRA subscriber of a state agency, public school district, participating county or other eligible employer, and their dependents who is enrolled in a benefits plan. See also *Covered Person*.

TERI

Teacher and Employee Retention Incentive program of the S.C. Retirement Systems.

Transfer/Transferring Employee

An active employee is considered a transferring employee if he moves from one state group employer to another with no more than a 15-calendar-day break in employment or no break in insurance coverage. An academic employee who completes a school term and moves to another academic setting at the beginning of the next school term is also considered a transferring employee. A transferring employee is not considered a new hire for insurance program purposes.

You

Any person who is insured under the policy. You and/or your covered dependents.